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No. 98-1949

Supreme Court, U.S.
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In The

Supreme Court of the United States

LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION, AND HEALTH ALLIANCE MEDICAL PLANS, INC.,

Petitioners,

v.

CYNTHIA HERDRICH,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

BRIEF *AMICI CURIAE* OF HEALTH CARE FOR ALL, AMERICAN PSYCHIATRIC ASSOCIATION, CENTER FOR HEALTH CARE RIGHTS, COMMUNITY CATALYST, CONNECTICUT CITIZEN ACTION GROUP, CONSUMERS FOR AFFORDABLE HEALTH CARE FOUNDATION, GREATER UPSTATE LAW PROJECT, INC., HEALTH ADMINISTRATION RESPONSIBILITY PROJECT, INC., NATIONAL HEALTH LAW PROGRAM, NEW HAMPSHIRE CITIZENS ALLIANCE, NORTHWEST HEALTH CARE ADVOCATES, PUBLIC INTEREST LAW CENTER, TEXAS CITIZEN FUND AND TEXAS HEART IN SUPPORT OF RESPONDENT

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INTEREST OF *AMICI CURIAE*

The *amici curiae* joining this brief are non-profit organizations representing health care users and providers, each of which has worked at the state or federal level to help ensure that individuals can obtain the health care that they need. These organizations, which serve a wide geographic area, include: Health Care For All (Massachusetts), the American Psychiatric Association, The Center for Health Care Rights (California), Community Catalyst, Connecticut Citizen Action Group, Consumers for Affordable Health Care Foundation (Maine), Greater Upstate Law Project (New York), Health Administration Responsibility Project (California), National Health Law Program, New Hampshire Citizens Alliance, Northwest Health Care Advocates (Washington), Public Interest Law Center (New Jersey), Texas Citizen Fund, Texas Heart.

Each of these organizations has either represented individuals or engaged in advocacy on behalf of patients of managed-care organizations.[1] These patient and provider groups have joined together because they each believe that the resolution of the issues raised by this case is critical to ensuring that patients in managed-care organizations are able to access meaningfully the health care benefits which they have been promised. A more complete description of each organization signing this brief is provided in Appendix A.

SUMMARY OF THE ARGUMENT

The Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq. ("ERISA"), was designed to protect beneficiaries of employee welfare plans from abuses by plan fiduciaries. Congress has never suggested

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[1] Counsel for the *amici curiae* authored this brief in its entirety. No person or entity, other than the *amici curiae*, their members or counsel, made a monetary contribution to the preparation or submission of this brief. Letters of consent from the parties have been filed with the Clerk of this Court.

that ERISA's protections do not apply to the millions of Americans who rely on employer-provided managed-care health plans.

The determination of whether a health insurance company that contracts with an ERISA plan is a fiduciary must be made in light of ERISA's multiple goals of protecting beneficiaries, encouraging the establishment of health care plans, and respecting the norms of federalism. Petitioners' untenable and unprecedented goal – immunity from both state and federal law for their alleged breaches – is an improper effort to manipulate ERISA preemption. Where a defendant that controls access to benefits under an ERISA plan has successfully moved to preempt state law claims, that defendant is subject to ERISA's fiduciary obligations.

The allegation that an ERISA fiduciary has established an incentive system that profits the fiduciary's principals by discouraging the provision of benefits promised under the plan states a cause of action cognizable under ERISA. An ERISA fiduciary's sole obligation, whether or not faced with dual loyalties, is to act in the interests of the beneficiaries. When acting as such, a fiduciary must seek to bring its conflicting interests to a resolution consistent with ERISA's goals. Placing such an obligation on managed-care entities will neither threaten the viability of managed care nor open the floodgates to litigation. Rather, it will simply ensure that the beneficiaries of managed-care health benefit plans established under ERISA have the same rights Congress granted to all ERISA plan beneficiaries.

ARGUMENT

I. CONGRESS HAS NEVER AUTHORIZED THE EXEMPTION OF MANAGED-CARE ORGANIZATIONS FROM LEGAL OVERSIGHT.

This case arises at the intersection of ERISA and managed-care policies. When ERISA was enacted, managed care, as a form of health insurance, was relatively

rare. *See* Rand E. Rosenblatt et al., *Law and the American Health Care System* 543-44 (1997). Since the 1980s, managed care has grown dramatically. *See id.* at 544 (by 1995, 78 percent of all privately insured persons were enrolled in managed-care plans). Despite this growth, there is neither authority nor reason to conclude that Congress intended to exempt managed-care plans from both ERISA's own protections and available state law protections. To the contrary, ERISA's text, 29 U.S.C. § 1002(1) (clarifying that health plans are welfare plans under ERISA), as well as its joint goals of encouraging employers to offer benefit plans and protecting beneficiaries, require that settled principles of federalism and fiduciary obligation apply to entities that oversee employee managed-care health plans. *See Varity Corp. v. Howe*, 516 U.S. 489, 506 (1996) (discussing ERISA's fiduciary obligations); *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 654-55 (1995) (discussing the application of federalism to ERISA). These principles establish that the administrators of managed-care organizations ("MCOs") must be accountable under state law or ERISA itself.

A. Congress Designed ERISA To Protect Beneficiaries From Abuses By Those Who Administer And Control Employee Welfare Plans, Irrespective Of The Form Of Such Plans.

1. The majority of Americans receive their health insurance through employer-sponsored managed-care health plans.

This Court has noted the "centrality of pension and welfare plans in the national economy, and their importance to the financial security of the Nation's work force." *Boggs v. Boggs*, 520 U.S. 833, 839 (1997). Indeed, employer-sponsored health coverage is critical to a majority of Americans. In 1997, 151.7 million Americans received their health insurance through an employer-provided

plan. Robert Kuttner, *Health Policy Report: The American Health Care System: Employer-Sponsored Health Coverage*, 340 New Eng. J. Med. 248, 248 (1999). Obviously, ERISA's impact on the ability of beneficiaries to redress grievances against such plans is of critical importance.

Until the early 1980s, most employer-sponsored health plans provided "indemnity" coverage, in which insurance companies (or the employer plan itself) paid for medical care on a fee-for-service basis, without involving themselves in delivering or managing the care. *See* Rand E. Rosenblatt et al., *Law and the American Health Care System* 543 (1997). In the last two decades, largely in response to the rising costs of fee-for-service health care, many employer-sponsored plans switched to some form of "managed care." *Id.* at 544. *See also* Brief of Petitioners at 6. Although it exists in many different permutations, managed care attempts to control costs by integrating the financing and delivery of health care services. *See* John K. Iglehart, *Health Policy Report: The American Health Care System – Managed Care*, 327 New Eng. J. Med. 742, 742 (1992). As a result, MCOs conflate, to varying degrees, the functions of insurer with that of care provider. *See Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 358 (3d Cir.), *cert. denied*, 516 U.S. 1009 (1995) (recognizing "that the distinction between the quantity of benefits due under a welfare plan and the quality of those benefits will not always be clear . . . where the benefit contracted for is health care services rather than money to pay for such services . . . "); *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321, 1331-32 (5th Cir.), *cert. denied*, 506 U.S. 1033 (1992) (discussing the dual roles played by a managed-care entity engaged in utilization review). As a result, MCOs may not only control access to benefits, as did indemnity insurers, they can also affect the actual quality of care patients receive. *See* 965 F.2d at 1332.

2. ERISA was designed to protect beneficiaries from abuses by those who administer employee welfare plans.

The product of a decade of congressional study, *Nachman Corp. v. Pension Benefit Guaranty Corp.*, 446 U.S. 359, 375 (1980), ERISA was designed "to promote the interests of employees and their beneficiaries in employee benefit plans." *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90 (1983); *Boggs*, 520 U.S. at 845 (same). ERISA accomplishes this goal by establishing standards of conduct, responsibility, and obligations for fiduciaries of employee benefit plans, and by providing for appropriate remedies. *See* 29 U.S.C. §§ 1001(b), 1132(a).

In keeping with its "broadly protective purposes," *John Hancock Mut. Life Ins. Co. v. Harris Trust and Savings Bank*, 510 U.S. 86, 96 (1993), ERISA provides " 'a panoply of remedial devices' for participants and beneficiaries of benefit plans." *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 108 (1989) (*quoting Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985)). ERISA also creates federal fiduciary standards, enacted in response to evidence that benefit plan administrators faced "few and inadequate remedial consequences" for breaching their fiduciary duty to beneficiaries. *See* Dahlia Schwartz, *Note: Breathing Lessons for the ERISA Vacuum: Toward a Reconciliation of ERISA's Competing Objectives in the Health Benefits Arena*, 79 B.U. L. Rev. 631, 636 (1999). ERISA requires "the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, . . . [and] establish[es] standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and . . . provid[es] for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. § 1001(b); *see also Varity Corp. v. Howe*, 516 U.S. 489, 513 (1996).

B. Federal Laws Supporting The Growth Of Managed Care Do Not Establish Any Congressional Intent To Immunize Managed-Care Organizations From Legal Accountability.

Because MCOs assume some or all of the financial risk of providing health care, they have a strong incentive to control costs. *See* Eleanor D. Kinney, *Procedural Protections for Patients in Capitated Health Plans*, 22 Am. J. L. & Med. 301, 305 (1996). *See also* Brief of Petitioners at 3. Managed care promotes more cost-conscious care. *See, e.g.*, Marc A. Rodwin, *Managed Care and Consumer Protection: What Are the Issues?*, 26 Seton Hall. L. Rev. 1009, 1009 n.1 (1996). Financial incentives to physicians for reducing the costs of care are but one of many cost containment strategies used by MCOs. *See* Iglehart, *supra*, at 742.

Beginning with the federal Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e *et seq.*, Congress has sought to encourage the growth of managed care in order to help control health care costs, by reducing inefficiency and waste in the health care system. However, Congress has never immunized health maintenance organizations ("HMOs") or other MCOs from accountability. To the contrary, federal legislation pertaining to managed care has consistently demonstrated Congress' intent to protect the interests of patients, even while promoting cost conscious health care delivery.

1. The federal Health Maintenance Organization Act does not exempt managed-care organizations from ERISA or any other source of legal oversight.

The Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e *et seq.*, attempted to spur the growth of private, cost-efficient HMOs and to expand availability of HMO plans to employees. *See* S. Rep. No. 93-129 (1973), *reprinted in* 1973 U.S.C.C.A.N. 3033, 3039-40 (noting with approval expert opinion that some form of HMO is

needed to restructure system more efficiently). The Act accomplished these goals by providing loans and loan guarantees to HMOs that met strict federal requirements and by setting criteria for employer-sponsored HMO plans. *See* 42 U.S.C. §§ 300e-4, 300e-9. Since federal loan availability under the Act ceased in 1986, 42 U.S.C. § 300e-4(d), the law has served primarily an "accreditation function to provide an imprimatur of quality for employers and other payers for HMO services." *See* Kinney, *supra*, at 314.

Petitioners aver that by supporting the development of HMOs, Congress has unqualifiedly sanctioned managed-care cost-containment measures. Brief of Petitioners at 4, 46. Mere encouragement of HMOs cannot be equated with a judgment that *all* such arrangements are exempt from ERISA or other legal oversight. In fact, federal qualifying criteria for HMOs, including grievance procedures and solvency requirements, indicate Congress' concern that protection of consumers not be sacrificed for cost concerns. *See* 42 U.S.C. §§ 300e(c)(1) and (5). Moreover, the HMO Act never sanctioned – or even suggested – the eradication of either state laws' or ERISA's essential protections against abuses by fiduciaries of HMO-style employee benefit plans.

2. The managed-care provisions of the Social Security Act demonstrate Congress' intent to protect beneficiaries while encouraging the growth of quality managed care.

Beginning in the 1980s, Congress began promoting enrollment of Medicaid and Medicare beneficiaries in HMOs as a way of reducing federal expenditures. *See* Kinney, *supra*, at 305-6. Congress thus authorized the Health Care Financing Administration ("HCFA") in 1982 to contract with federally qualified HMOs, *see* 42 U.S.C. § 300e-9(d), and other approved HMOs and "competitive

medical plans," to provide care to Medicare beneficiaries. 42 U.S.C. § 1395mm(b). With passage of the Balanced Budget Act of 1997, Pub. L. 105-33, 111 Stat. 251, Congress expanded the range of managed-care arrangements eligible to be Medicare providers. *See* 42 U.S.C. § 1395w-21(a)(2)(A) (authorizing enrollment in "coordinated care plans," including HMOs, "preferred provider organization plans" and "provider sponsored organizations").

To participate in the Medicare program, managed-care organizations must meet numerous conditions designed to protect beneficiaries. *See* 42 U.S.C. § 1395mm (b)(2); 42 U.S.C. § 1395w-22. These conditions include compliance with open enrollment requirements, disclosure of certain information to beneficiaries, providing "meaningful" procedures for hearing and resolving grievances, and establishing an ongoing quality assurance program. 42 U.S.C. § 1395mm(c) (protections under former risk contract program); 42 U.S.C. §§ 1395w-21(e), 1395w-22(c), (e), (f) and (g) (enhanced protections under Medicare+Choice program).

Congress has also authorized the provision of Medicaid benefits through managed-care arrangements. *See* 42 U.S.C. § 1396b(m). As with the Medicare program, a detailed regulatory scheme exists to protect beneficiaries. In order to qualify as a Medicaid provider, an MCO must ensure access to services, meet solvency standards, not discriminate based on health status, and disclose specified information to beneficiaries. *See id.*

Significantly, Congress expressly restricted the physician incentives allowed in MCOs that contract with the Medicare and Medicaid programs. *See* 42 U.S.C. § 1395mm(i)(8); 42 U.S.C. § 1395w-22(j)(4); and 42 U.S.C. § 1396b(m)(2)(A)(x) (incorporating Medicare rule). Medicare and Medicaid MCOs are prohibited from making payments to physicians, whether direct or indirect, as an

inducement to reduce or limit medically necessary services to a specific enrollee. *See, e.g.*, 42 U.S.C. § 1395w-22(j)(4)(i). Moreover, to ensure against injury to beneficiaries, the statutes require stop-loss insurance protection of physicians and physician groups that are placed at substantial financial risk. *See, e.g.*, 42 U.S.C. § 1395w-22(j)(4)(ii)(I). Finally, the law requires HCFA to monitor the effect of physician incentives on beneficiary access to quality services.[2] *See, e.g.*, 42 U.S.C. § 1395w-22(j)(4)(ii)(II). The Medicare+Choice statute also prohibits so-called "gag" clauses that prevent physicians from communicating the full range of treatment options to patients. 42 U.S.C. § 1395w-22(j)(3). These provisions, viewed together, reflect Congress' well-founded concern that managed-care financial incentive schemes may have the effect of reducing the services provided to program beneficiaries.

Although the Medicare and Medicaid managed-care laws are not applicable in the instant case, they show that even while promoting managed care, Congress recognized the potential dangers arising from physician incentive schemes. With Medicare and Medicaid, Congress sought to encourage managed care, but not without ensuring adequate protections for the beneficiaries.

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[2] The Medicaid statute also provides for oversight of financial transactions of non-federally qualified HMOs that potentially pose a conflict of interest. *See* 42 U.S.C. § 1395b(m)(4)(A) (requiring disclosure of transactions between Medicaid MCO and party in interest).

II. WHERE CLAIMS PERTAINING TO THE CREATION OF A FINANCIAL INCENTIVE SCHEME HAVE BEEN HELD PREEMPTED BY ERISA, THEY MUST BE FOUND TO CONCERN THE ACTIONS OF A FIDUCIARY UNDER ERISA.

A. The Concept Of A Fiduciary Under ERISA Must Be Understood In Light Of The Statute's Goals And Its Relationship To State Law.

The fiduciary has been aptly termed the "linchpin" in ERISA's scheme of flexible regulation. John H. Lanbein & Bruce A. Wolk, *Pension and Employee Benefit Law* 626-627 (2d ed. 1995). The essential role played by the fiduciary must be understood in light of ERISA's scheme of cooperative federalism. *See* 29 U.S.C. § 1144(a). As this Court has recently noted, ERISA preemption of state laws regulating matters traditionally left to the state, such as health care, is not to be lightly presumed. *See New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 654-55 (1995). Moreover, to the extent that preemption is appropriate to prevent potentially disuniform regulation of employee benefit plans,[3] it should not be read to shelter entities that administer such plans from any legal oversight, *"but rather as a means to promote the principal object of ERISA as a whole – 'to protect plan participants and beneficiaries.' " Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 58 (D. Mass. 1997) (emphasis added). Federal displacement of state law does not erase any and all accountability. Thus, when a state law action

[3] Even when a state law or action "relates to" an employee benefit plan, it will not be preempted if it falls within the scope of ERISA's "saving clause," 29 U.S.C. § 1144(b)(2)(A), and does not implicate the "deemer clause," 29 U.S.C. § 1144(b)(2)(B) (1999). *See UNUM Life Ins. Co. v. Ward*, 526 U.S. 358, ___, 119 S. Ct. 1380, 1386 (1999). The instant case does not implicate either clause, as the respondent did not bring her initial action under a state law regulating insurance. Petition for Certiorari at 66a.

is preempted because the matter "relates to" an ERISA plan, the presumption must be that the matter falls within ERISA's fiduciary-based system of regulation.[4] For if there is no ERISA jurisdiction over the matter, it is difficult to see how the state action "relates to" an ERISA plan. But when a state law is found to "relate to" plan administration on the grounds that it concerns actions of the defendants as fiduciaries, the same actions cannot then be held outside ERISA's fiduciary duties as merely "indirect" provision of services. *See* Brief of Petitioners at 18. Either the federal or the state system must have jurisdiction over the matter. There is no extra-territorial immunity for plan administrators.

B. Petitioners' Untenable And Unprecedented Goal – Immunity From Both State And Federal Oversight For Their Alleged Breaches – Should Be Rejected By This Court As An Improper Effort To Manipulate ERISA Preemption.

Petitioners seek to benefit from ERISA's preemptive shield without coming under ERISA's scrutiny. In resisting the motion to remand the case to state court, petitioners admitted to being fiduciaries within the meaning of ERISA, implicitly conceding that they were subject to ERISA's fiduciary duties. *Herdrich v. Pegram*, 154 F.3d 362, 369 n.5 (7th Cir. 1998), *rehearing en banc denied*, 170 F.3d 683 (1999). Now, after successfully arguing for preemption and a federal forum,[5] petitioners claim before this

[4] This is not to say that an individual plaintiff will prevail under ERISA whenever a state law claim is preempted. ERISA provides its own standards of behavior, which will often differ from those applicable at state law. In addition, even when ERISA applies to a claim, relief may be unavailable. *See, e.g., Mertens v. Hewitt Associates*, 508 U.S. 248, 260-61 (1993).

[5] In its opinion in favor of the respondent, the Seventh Circuit noted that the parties "took dramatically different

Court that they are not fiduciaries. Brief of Petitioners at 22-42. In addition, they attempt to turn their exercise of removal jurisdiction on its head, arguing that the decision below undermines principles of federalism by paving the way for excessive preemption. Brief of Petitioners at 38. In making this argument, petitioners forget that it was they who successfully sought preemption in the first place, and that they already prevailed upon that issue.

Petitioners' extraordinary attempt to play state and federal jurisdiction against each other and convert preemption into total immunity from legal oversight is without precedent. Even those who have argued that ERISA preemption is too broad have done so in the belief that ERISA's remedies are often inadequate. *See, e.g.*, *Corcoran*, 965 F.2d at 1331; *Andrews-Clarke*, 984 F. Supp. at 59. *See also* Jayne Elizabeth Zanglein, *Closing the Gap: Safeguarding Participants' Rights by Expanding the Federal Common Law of ERISA*, 72 Wash. U. L.Q. 671 (1994). But no authority has suggested that ERISA is entirely inapplicable to an action that has previously been preempted. Indeed, petitioners do not cite a single case in which a federal court has excused a defendant altogether from accountability

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positions from what they now argue on appeal concerning the issue of whether the defendants were plan fiduciaries . . . Herdrich originally maintained that the defendants were not plan fiduciaries, while the defendants insisted that they were." *Herdrich v. Pegram*, 154 F.3d 362, 369 n.5 (7th Cir. 1998), *rehearing en banc denied*, 170 F.3d 683 (1999). This Court has held that "where a party assumes a certain position in a legal proceeding, and succeeds in maintaining that position, he may not thereafter, simply because his interests have changed, assume a contrary position, especially if it be to prejudice the party who has acquiesced in the position formerly taken by him." *Davis v. Wakelee*, 156 U.S. 680, 689 (1895) (citations omitted); *cf. Utermehle v. Norment*, 197 U.S. 40, 57-58 (1905) (holding that one who receives a beneficial interest pursuant to a will is estopped from later challenging the validity of the will).

after that defendant prevailed in preempting a state claim on grounds that the state claim implicated the defendant's status as an ERISA plan fiduciary. Heretofore, the federal courts have either found preemption and proceeded to determine whether a fiduciary breach has occurred, *e.g.*, *Smith v. Provident Bank*, 170 F.3d 609, 612 (6th Cir. 1999); *Joyce v. RJR Nabisco Holdings Corp.*, 126 F.3d 166, 172 (3d Cir. 1997); *Corcoran*, 965 F.2d at 1331, or remanded the case back to state court. *E.g.*, *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d at 356-57 (finding complete preemption inappropriate in an analysis that suggests that state law should not be preempted).

Nowhere is there a greater need to recognize the interrelationship between preemption and federal jurisdiction over fiduciaries than with HMOs, which blur traditional divisions among health care providers, health insurers and plan administrators. Brief of Petitioner at 3-4; Solicitor General's Brief at 11-13, 24-27. *See also* Rand E. Rosenblatt et al., *supra*, at 544. This difficulty in ascertaining the actual role, or roles, played by an HMO in a given situation has complicated the ERISA analysis. *Dukes*, 57 F.3d at 361.

In the last few years, however, courts have held that when managed-care entities are performing a clinical role, as providers of health care, they are not ERISA fiduciaries. *Id.* Hence, claims challenging the *quality* of care are appropriately left to state law. *Id.* Conversely, claims pertaining to the determination of benefits by managed-care entities are generally preempted but subject to review under ERISA. *See, e.g.*, *Corcoran*, 965 F.2d at 1331.

Count III of Ms. Herdrich's amended complaint does not challenge clinical decisions made by the petitioners. Indeed, the clinician who treated Ms. Herdrich, Dr. Pegram, was not a party to Count III. *See* Petition for Certiorari at 84a. Petitioner HAMP is not a clinician, but rather a domestic stock insurance company entrusted by

the State Farm ERISA plan to manage the HMO option. Brief of Petitioners at 6-7. In other words, although the plan HAMP managed for State Farm's employee benefit plan was an HMO option (with care provided by Carle Clinic), *id.*, HAMP itself acted as a plan administrator, *not* a health care provider.

The fact that, like many HMOs, petitioners commingled the roles of insurer, administrator and provider (in that HAMP's directors were also the owners and physicians of Carle Clinic, *see id.*) does not permit them to escape accountability for their activities as overseers of the employee benefit plan. To the extent that petitioners, especially HAMP, controlled access to State Farm plan benefits and were therefore able to preempt the respondent's state law claims, they should be treated as fiduciaries under ERISA. The complexity of managed care does not free its players from legal oversight. There is no void lying between state and federal law.

C. A Party's Status As A Fiduciary Under ERISA Turns On Its Function Rather Than Its Form.

Assuming that state law has properly been preempted, the determination of whether the petitioners are fiduciaries must be made consistent with the goals and text of ERISA itself. As this Court has noted, ERISA:

> says that a "person is a fiduciary with respect to a plan," and therefore subject to ERISA fiduciary duties, "to the extent" that he or she "exercises any discretionary authority or discretionary control respecting management" of the plan, or "has any discretionary authority or discretionary responsibility in the administration" of the plan.

Varity Corp., 516 U.S. at 498, *citing* ERISA § 3(21)(A). Consistent with ERISA's policies and objectives, the statutory definition of a "fiduciary" is construed liberally. *See, e.g., John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 96 (1993); *Smith v. Hartford Ins. Group*, 6 F.3d 131, 141 n.13 (3d Cir. 1993), *cert. denied*, 522 U.S. 932 (1997). Fiduciary status under ERISA is not an "all-or-nothing concept," *see* Clifford A. Cantor, *Fiduciary Liability in Emerging Health Care*, 9 DePaul Bus. L. J. 189, 191 (1997), *citing Coyne & Delany Co. v. Selman*, 98 F.3d 1457, 1465 (4th Cir. 1996), but rather, enables a party who wears "two hats," *see Amato v. Western Union Int'l, Inc.*, 773 F.2d 1402, 1416-17 (2d Cir. 1985), *cert. dismissed*, 474 U.S. 1113 (1986), to be considered a fiduciary "to the extent" that the hat worn permits discretion or control over the ERISA plan. *See id.; Curcio v. John Hancock Mut. Life Ins. Co.*, 33 F.3d 226, 233-34 (3d Cir. 1994). *See also Varity Corp. v. Howe*, 516 U.S. 489, 498 (1996). Accordingly, ERISA expands the universe of persons subject to fiduciary duties by defining fiduciary "not in terms of formal trusteeship, but in functional terms of control and authority over the plan." *Mertens v. Hewitt Assoc.*, 508 U.S. 248, 262 (1993), *citing* 29 U.S.C. § 1002(21)(A). This liberal and functional approach to fiduciary status is especially appropriate where preemption has occurred.

Petitioners attempt to evade this approach by arguing that the sole "benefit" available to State Farm plan beneficiaries like respondent is "membership in the Carle Care HMO." Brief of Petitioners at 25. This argument ignores this Court's prior analysis which rejects such an unduly narrow version of what constitutes the "benefit" available to a plan participant. *See, e.g., Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 43-44 (1987). When coupled with petitioners' position on preemption, this view would undermine the broad protections and intentions of ERISA. Tellingly, the petitioners point to no authority for their position (aside from Judge Easterbrook's dissent, *see Herdrich v. Pegram*, 170 F.3d 683 (7th Cir. 1999) (Easterbrook, J., dissenting)), because there is nothing in ERISA or its legislative history to suggest such a radical diminution of accountability. To the contrary, in applying

ERISA's fiduciary definition in the managed-care context, the federal courts have found that if, as respondent alleges, Petition for Certiorari at 85a, an HMO exercises discretion and control over the administration or management of the plan, the HMO is acting as a fiduciary for purposes of ERISA.[6] *See, e.g., Shea v. Esensten*, 107 F.3d 625, 628-29 (8th Cir.), *cert. denied*, 522 U.S. 914 (1997); *O'Reilly v. Ceuleers*, 912 F.2d 1383, 1385 (11th Cir. 1990); *Weiss v. CIGNA Healthcare, Inc.*, 972 F. Supp. 748, 751 (S.D.N.Y. 1997); *Drolet v. Healthsource, Inc.*, 968 F. Supp. 757, 761 (D.N.H. 1997). *See also* Cantor, *supra*, at 191-92 ("Each of the parties involved in operating a modern health plan can be a fiduciary with respect to those activities over which it has discretion. Those parties include the plan sponsor, insurer, third-party administrator, and various types of managed care entities, among others.").

Contrary to petitioners' suggestion, the Court of Appeals' decision does not demand that ERISA fiduciary status be found whenever "any act or decision by a health-care provider [. . .] *indirectly* affect[s] benefits provided under an ERISA plan." Brief of Petitioners at 31 (emphasis added). Rather, as the Solicitor General aptly

[6] The duty to disclose material information is at the core of a fiduciary's responsibility under the common law of trusts. Trustees must neither mislead nor deceive plan beneficiaries. *Varity Corp.*, 516 U.S. at 506. The first two courts to consider whether ERISA requires MCOs to disclose the existence of physician incentive schemes to enrollees found the MCOs in question to be ERISA fiduciaries. *See Shea v. Esensten*, 107 F.3d 625 (8th Cir.), *cert. denied*, 522 U.S. 914 (1997); *Weiss v. CIGNA Healthcare, Inc.*, 972 F. Supp. 748 (S.D.N.Y. 1997). A holding that petitioners are neither subject to state law nor acting as ERISA fiduciaries in devising a financial incentive scheme, in which savings resulting from the withholding of care went into the physician-owners' pockets, would implicitly mean that *Shea* and *Weiss* were wrongly decided.

asserts in his *amicus* brief to this Court, in the context of managed care:

> [I]nsofar as an HMO exercises "discretionary authority or discretionary responsibility in the administration of the plan, it takes on fiduciary status under ERISA. 29 U.S.C. § 1002(21)(A). Activities that constitute administration of the plan include determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records to comply with applicable reporting requirements. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987). In the context of the HMO, the relevant administrative functions frequently performed by an HMO consist of determining eligibility under the ERISA plan, determining whether a particular treatment is covered by the plan, sending required notices and filing reports, and keeping necessary records. An HMO is an ERISA fiduciary only when and insofar as it exercises discretionary control over those activities.

Solicitor General's Brief at 18-19 (internal quotations omitted).

In this case, respondent has alleged that petitioners exercise significant discretion over the activities detailed above. As the Seventh Circuit found, the respondent's complaint alleged, *inter alia*, that the petitioners were "in control of each and every aspect of the HMO's governance . . . [and] had the exclusive right to decide all disputed and non-routine claims." *Herdrich*, 154 F.3d at 370. The Court of Appeals concluded correctly that the petitioners' degree of control and discretion – particularly their control and discretion over the granting or denial of benefits – was sufficient to satisfy ERISA's fiduciary requirements. *Id*. Other courts have likewise found the controllers of managed-care plans to be fiduciaries. *See*,

e.g., Bailey v. Blue Cross & Blue Shield of Virginia, 67 F.3d 53, 56 (4th Cir. 1995), *cert. denied*, 516 U.S. 1159 (1996); *Reich v. Lancaster*, 55 F.3d 1034, 1047 (5th Cir. 1995); *Florence Nightingale Nursing Serv. v. Blue Cross & Blue Shield of Alabama*, 41 F.3d 1476, 1478-79 (11th Cir.), *cert. denied*, 514 U.S. 1128 (1995); *Pacificare, Inc. v. Martin*, 34 F.3d 834, 837 (9th Cir. 1994); *Libbey-Owens-Ford Co. v. Blue Cross & Blue Shield Mut.*, 982 F.2d 1031, 1035 (6th Cir.), *cert. denied*, 510 U.S. 819 (1993); *Reilly v. Blue Cross & Blue Shield United of Wisconsin*, 846 F.2d 416, 419 (7th Cir.), *cert. denied*, 488 U.S. 856 (1988).

The court's analysis in *Drolet v. Healthsource, Inc.*, 968 F. Supp. 757 (D.N.H. 1997), is pertinent. In *Drolet*, the defendants, a health care corporation and its wholly-owned HMO subsidiary, argued that they were not ERISA fiduciaries, and therefore, could not be held liable for misrepresentations or omissions regarding the financial incentive scheme employed to reward physicians for reducing health care expenditures. *See id.* at 758, 760. In denying defendants' motion to dismiss, the court relied on ERISA's use of the term "control" in the statutory definition of fiduciary. The court stated:

> The term "control" in the [statutory definition of fiduciary] has been interpreted as "the power to exercise a controlling influence over the management of policies of a person other than an individual." 29 C.F.R. § 2510.3-21(e)(2) (1996). [The plaintiff] satisfactorily alleges in her complaint that [the HMO] has the discretionary authority and control over the plan to qualify it as a fiduciary. Moreover, [the HMO] conceded at the hearing on the motion to dismiss that it exercises final control over benefits appeals. As such, it plainly qualifies as a fiduciary under ERISA. *See Varity Corp.*, 116 S.Ct. at 1077; *Libbey-Owens-Ford Co. v. Blue Cross and Blue Shield Mut.*, 982 F.2d 1031, 1035 (6th Cir. 1993); *American Fed'n of Unions v. Equitable Life Assurance Soc'y*, 841 F.2d 658, 663 (5th Cir. 1988). [The plaintiff] also adequately alleges that [the corporate owner] controls the policies and practices of [the HMO] to such an extent that it also exercises control over the management and policies of the plan. *See Johnson v. Flowers Indus.*, 814 F.2d 978, 981 (4th Cir. 1987).

Drolet, 968 F. Supp. at 761 (other citations and parentheticals omitted). Although obviously not binding on this Court, *Drolet* provides a useful paradigm for analyzing the application of ERISA's fiduciary concepts to managed care.

Petitioners suggest that even if they are fiduciaries in some respect, the allegations of Count III do not implicate actions they undertook in that capacity. First, petitioners argue that the financial incentive scheme at issue is a matter of plan design and therefore is not subject to ERISA's fiduciary standards. Brief of Petitioners at 26-30. Although petitioners correctly state that decisions of the employer-settlor in determining the nature and extent of benefits do not constitute fiduciary action, *see* 29 U.S.C. § 1002(1), there is nothing in the record to suggest that State Farm knew or approved of the specific incentive plan that serves as the basis for Count III. The fact that State Farm's ERISA plan offered a managed-care product that utilized cost-containment measures does not mean that it chose – let alone required – the particular financial incentive scheme at issue here.

Many courts have held that through the discretionary administration of employee health plans, including the development of physician incentive schemes, managed-care organizations assume ERISA fiduciary status. *See, e.g., Shea v. Esensten*, 107 F.3d 625, 627 (8th Cir.), *cert. denied*, 522 U.S. 914 (1997); *O'Reilly v. Ceuleers*, 912 F.2d 1383, 1386 (11th Cir. 1990); *Weiss v. CIGNA Healthcare, Inc.*, 972 F. Supp. 748, 751 (S.D.N.Y. 1997); *Morales v. Health Plus, Inc.*, 954 F. Supp. 464, 468 (D.P.R. 1997). Based on similar reasoning, the court in *Corcoran v. United*

HealthCare, Inc., 965 F.2d at 1331, after preempting state law claims, held that a "utilization review" by a utilization review organization[7] constituted administration of an ERISA benefits plan and was subject to review under ERISA. As with utilization review, a physician incentive plan designed to reduce care implicates, albeit indirectly, the availability of benefits under a managed-care ERISA plan. The simple fact that petitioners created a scheme designed to influence access to benefits rather than engage in a case-by-case determination of coverage does not alter the discretionary, administrative nature of the activity and hence, their fiduciary status.

III. ALLEGATIONS THAT A FIDUCIARY ESTABLISHED AN INCENTIVE SCHEME TO BENEFIT THE FIDUCIARY'S PRINCIPALS BY DISCOURAGING PROVISION OF CARE STATE A COGNIZABLE CLAIM FOR BREACH OF FIDUCIARY DUTY UNDER ERISA.

A. An ERISA Fiduciary's Sole Obligation, With Or Without Dual Loyalties, Is To Act In The Interests Of The Beneficiaries.

When a state law action against a MCO has been preempted and the MCO is found to be a fiduciary, the MCO becomes subject to ERISA's fiduciary duties. In contrast to pension plans, about which ERISA contains myriad specific regulations, *see* 29 U.S.C. §§ 1054-56, 1081,

[7] Utilization review organizations hire physicians and nurses to review each insured patient's records to determine if prescribed treatments are medically necessary. *See* Allison Faber Walsh, *The Legal Attack on Cost Containment Mechanisms: The Expansion of Liability for Physicians and Managed Care Organizations*, 31 J. Marshall L. Rev. 207, 216 (1997). If the reviewer determines that the treatment is not medically necessary, the beneficiary does not receive the treatment. *See id.*

1221-1222, the statute has few detailed requirements pertaining to welfare plans. The beneficiaries of welfare plans, however, are not left without legal protection, for ERISA explicitly asserts that its sections pertaining to "fiduciary responsibilit[ies]" apply to "any employee benefit plan." 29 U.S.C. § 1001(a)(1). Nothing in the statute exempts the fiduciaries of health plans in general, or managed-care health plans in particular, from those responsibilities.

First and foremost among the fiduciary responsibilities is the duty of loyalty. ERISA states that the plan's fiduciary "shall discharge his duties with respect to a plan solely in the interests of the participants and beneficiaries and (a) for the exclusive purpose of (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan." 29 U.S.C. § 1101(a). The statute further provides that plan assets may not be used except in specified circumstances (none of which are applicable here) for the "benefit of a party in interest." 29 U.S.C. § 1106(a)(1)(d).

ERISA's duty of loyalty derives from the common law of trusts. *See* S. Rep. No. 93-127 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4838, 4864 ("The fiduciary responsibility section, in essence, codifies and makes applicable to these fiduciaries certain principles developed in the evolution of the law of trusts"). *See also Varity Corp. v. Howe*, 516 U.S. at 506 (discussing the relationship between ERISA's duty of loyalty and the common law of trusts.) As a result, courts are to look to common law principles in deriving the meaning and content of ERISA's duty of loyalty. *See id.; Firestone Tire and Rubber*, 489 U.S. at 110.

Under common law, the duty of loyalty was the "most fundamental duty owed by a trustee to the beneficiaries. . . . " IIA *Scott on Trusts* § 170, at 311 (4th ed. 1987). As Justice Benjamin Cardozo noted almost three-quarters of a century ago: "A trustee is held to something

stricter than the morals of the marketplace. Not honesty alone, but the punctilio of an honor the most sensitive, is then the standard of behavior." *Meinhard v. Salmon*, 249 N.Y. 458, 464, 164 N.E. 545, 546 (1928). In order to enforce this very strict requirement, the law of trusts forbids absolutely many forms of self-dealing by fiduciaries, even when such self-dealing may not result in harm to the beneficiary. *See* IIA *Scott on Trusts, supra* at § 170, at 311-312.

The common law of trusts, however, is merely a jumping-off point for interpreting ERISA's duty of loyalty. As this Court has noted, when construing ERISA, courts must look not only to the common law but also to "Congress' desire to offer employees enhanced protection for their benefits, on the one hand, and, on the other, its desire not to create a system that is so complex that administrative costs or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place." *Varity Corp.*, 516 U.S. at 497.

In recognition of these multiple goals, ERISA stops short of declaring certain conflicts of interests by fiduciaries as per se breaches of fiduciary duty. Laurence B. Wohl, *Fiduciary Duties Under ERISA: A Tale of Multiple Loyalties*, 20 Dayton L. Rev. 43, 55 (1994). Most notably, ERISA permits employers and their agents to serve as fiduciaries, even when this presents certain conflicts of interest. This *limited* tolerance of conflicts of interest by employers and their agents is consistent with the statute's goal of encouraging employers to establish employee welfare plans. There is no need for such an accommodation of dual loyalties where, as here, the fiduciary has played no part in establishing the welfare plan and the alleged conflict arises from the fact that it is the directors of HAMP, as physicians, who may benefit personally from denying beneficiaries access to promised benefits. Petition for Certiorari at 86a. This conflict has no relation

at all to ERISA's goals of encouraging employers to establish welfare plans.

Although ERISA permits fiduciaries in some circumstances to have dual loyalties, it does not permit them, when acting in their fiduciary role, to make decisions that advance their interests to the detriment of the beneficiaries. To the contrary, fiduciary actions must be taken with an "eye single" to the interest of the beneficiaries. *Donovan v. Bierwirth*, 680 F.2d 263, 271 (2d Cir. 1982). *See also Leigh v. Engle*, 858 F.2d 361, 364 (7th Cir. 1988); *Pitman v. Blue Cross & Blue Shield of Oklahoma*, 24 F.3d 118, 123 (10th Cir. 1994). Any other outcome would eviscerate the very notion of a fiduciary and would make meaningless ERISA's edict that fiduciaries act in the interest of the beneficiaries. 29 U.S.C. § 1104(a)(1). This Court has never condoned such a departure from basic fiduciary principles.

Applying ERISA's fiduciary obligations to managed care, when state law is preempted, will not, as petitioners imply, Brief of Petitioners at 46, threaten the existence of managed-care plans. The fiduciary's obligation is not to please a particular beneficiary but to afford the beneficiary the benefits promised by the plan, typically medically necessary care, while preserving the interests of the plan as a whole. Thus, where a health benefit plan expressly limits benefits (as does the plan at issue), Joint Appendix at 83-88 (limiting coverage of prescription drugs, ineligible charges and pre-existing conditions), an ERISA fiduciary does not violate its obligations by denying those benefits. *E.g.*, *Fuja v. Benefit Trust Life Insurance Co.*, 18 F.3d 1405, 1411 (7th Cir. 1994). However, where as here, a fiduciary devises a system that limits the beneficiaries' ability to obtain benefits promised in order to promote the interests of the fiduciary and its principals, a breach of trust has occurred.

B. When Acting In The Fiduciary Role, Plan Administrators Are Not Free To Ignore Their Conflict Of Interest But Must Seek To Bring Their Conflicting Interests To A Resolution Consistent With ERISA's Goals.

The petitioners misapply the teaching of *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 119 S. Ct. 755 (1999). In *Hughes*, an employer, acting in his nonfiduciary capacity, amended a pension plan. The Court held that the employer's concurrent but separate fiduciary status as administrator of the pension plan's assets was not implicated, despite the fact that the employer was acting in its financial self-interest to the detriment of its employees. 119 S. Ct. at 760-63. Essentially, the Court held that as long as the decision is taken while acting outside the fiduciary role, fiduciary principles do not apply.[8] *Id.*

The *Hughes* scenario does not exist in this case. Ms. Herdrich is challenging the incentive scheme created by the petitioners, primarily HAMP, in contracting with Carle Clinic for medical services. Petition for Certiorari at 84a-87a. To the extent that these actions have been found to be outside the purview of state law, and within the realm of ERISA, they are solely actions undertaken as a fiduciary, not as a settlor. Within ERISA's framework, the conflict is not between two roles, one fiduciary and one non-fiduciary, as in *Hughes*. The conflict that exists here arises in the exercise of the fiduciary role itself.

The distinction between a case where a fiduciary is acting in dual roles and one in which the conflict arises solely in connection with the exercise of a fiduciary obligation is crucial. *Hughes* stands for the proposition that an

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[8] The observations regarding *Hughes* are equally applicable to *Lockheed Corp. v. Spink*, 517 U.S. 882 (1996). The *Lockheed* Court held that plan sponsors who alter the terms of a plan do not fall into the category of fiduciaries because their actions are analogous to those of the settlors of a trust. *Id.* at 891.

employer may disregard the interests of employees when amending its pension plan. But as this Court has emphasized repeatedly, *see, e.g., Varity Corp.*, 516 U.S. at 506, when a fiduciary is operating *within* its fiduciary role, the duty of loyalty to plan beneficiaries is paramount.

ERISA fiduciaries, of course, often face a conflict between loyalty to pension plan beneficiaries and cost-containment measures which benefit the plan as a whole. As the Court stated in *Mertens*, "[t]here is . . . a tension between the primary ERISA goal of benefiting employees and the subsidiary goal of containing pension costs. We will not attempt to adjust the balance between those competing goals that the text adopted by Congress has struck." 508 U.S. at 262-63 (internal quotation marks, brackets and citations omitted).

Likewise, a tension exists whenever a health plan administrator must decide whether to authorize medical care, as such a decision affects the plan's financial health. In many such cases, federal courts have attempted to find a measured way to heighten the scrutiny of the plan administrator's decision, in recognition of the inherent conflicts. *See, e.g., Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 826-27 (10th Cir. 1996); *Doe v. Group Hospitalization Medical Servs.*, 3 F.3d 80, 87 (4th Cir. 1993); *Brown v. Blue Cross and Blue Shield of Alabama*, 898 F.2d 1556, 1568 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991). *See generally* Michael A. de Fraitas, *Annotation: Judicial Review of Denial of Health Care Benefits Under Employee Benefit Plan Governed by Employee Retirement Income Security Act (ERISA) (29 U.S.C.A. § 1132(a)(1)(B)) – Post Firestone Cases*, 128 A.L.R. Fed. 1 (1999). These courts, however, have never suggested that fiduciary duty principles are inapplicable due to such conflicts of interest.

Petitioner HAMP, like the plan administrator in the typical benefits administration case, was faced with the inherent conflict between saving the ERISA plan money

and serving the interests of the beneficiaries. But, according to the respondent's allegations in Count III, Petition for Certiorari at 84a-87a, which must be taken as true when reviewing a decision pertaining to a motion to dismiss, *Conley v. Gibson*, 355 U.S. 41, 45-46 (1957), HAMP and its alter-ego Carle Clinic opted to serve a third interest – their own. Thus, HAMP devised a plan that would benefit its principals to the detriment of the beneficiaries. Such self-dealing in a fiduciary capacity is critically different than the balancing of interests inherent in the ordinary administration of an ERISA plan. Where, as here, a plaintiff alleges that an incentive system is designed to deprive beneficiaries of the medical benefits promised by the plan, a cause of action for breach of fiduciary duty exists under ERISA.

C. Courts Are Well-Equipped To Review Allegations Of Breach Of Trust By Administrators Of Managed-Care Plans.

Federal courts have ample guides to help address the inherent conflict that exists in managed-care plans. Far from spelling the end of managed care, review of managed-care incentive schemes under ERISA is well within the competence of the courts. This is particularly true where the conflicts by HMO administrators mirror those addressed by ERISA – the protection of employee benefits and the controlling of costs.

Although the primary goal of ERISA is protection of employees, it is not the exclusive goal. *Mertens v. Hewitt Associates*, 508 U.S. 248, 262-63 (1993) (Scalia, J.) (*quoting Alessi v. Raybestos Manhattan, Inc.*, 451 U.S. 504, 515 (1981)). ERISA's subsidiary goal is containment of costs, and ERISA is founded on the premise that these two goals can be harmoniously resolved.

MCOs use a variety of approaches to achieve this balance. Most approaches are consistent with ERISA's

goals.[9] For example, capitation systems can advantage plan beneficiaries if the availability of a steady stream of payments permits providers to institute preventive care programs for enrollees. *See, e.g.*, Stephen R. Lathan, *Regulation of Managed Care Incentive Payments to Physicians*, 22 Am. J. Law & Med. 399, 401 (1996). As long as the incentives are chosen by the plan administrator to serve the interests of plan beneficiaries first, and itself second, the duty of loyalty is preserved. However, an incentive system that imprudently promotes under-utilization of medical care and benefits the administrator's own principals is a different matter.[10] *Cf. Schaefer v. Arkansas Medical Society*, 853 F.2d 1487, 1492 (8th Cir. 1988) (holding that a fiduciary with dual loyalties must follow the prudent person standard).

Although respondents were prevented from taking any meaningful discovery as to the specifics of the incentive scheme, the record reveals that the plan at issue here is not representative of the typical HMO. HAMP devised a system in which its physician-owners directly benefited

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[9] For example, managed care was originally known for its focus upon prevention, which may lower costs but also improve the patients' quality of health. *See, e.g.*, Jack K. Kilcullen, *Groping the Reins: ERISA, HMO Malpractice and Enterprise Liability*, 22 Am. J. Law & Med. 7, 21 (1998) ("Paul Elwood coined the term health maintenance in 1970 to stress the preventative nature of this form of pre-paid care."); Barry R. Furrow, *Managed Care Organizations and Patient Injury: Rethinking Liability*, 31 Ga. L. Rev. 419, 427-29 (1997).

[10] The American Medical Association's Council on Ethical and Judicial Affairs has recognized this danger, warning that under some circumstances, managed care may lead physicians to "cut corners in their patient care, by temporizing too long, eschewing extra diagnostic tests, or refraining from an expensive referral." Council on Ethical and Judicial Affairs, American Medical Association, *Ethical Issues in Managed Care*, 273 JAMA 330, 333 (1995). *See also* Marc A. Rodwin, *Medicine, Money and Morals: Physicians' Conflict of Interest* 145 (1993).

at the expense of the beneficiaries and the plan. Brief of Petitioners at 27, 33. Petitioners assert that physician-owners are no more likely than corporations or other HMO owners to contain costs at the expense of patient welfare, *id.* at 47, yet they ignore the fact that in the typical case, the same physicians do not act as both providers and administrators of the plan. Here, in contrast, petitioners faced multiple conflicts of interest beyond those posed in the more common scenario. If, acting under such conflicts, they devised a scheme that was designed to profit their principals to the detriment of the beneficiaries, they violated their duty of loyalty under ERISA.

D. Preservation Of A Cause Of Action For Breach Of Fiduciary Duty In A Managed-Care Setting Will Neither Threaten The Viability Of Managed Care Nor Open The Floodgates To Litigation.

Petitioners assert that permitting a cause of action for breach of fiduciary obligation by administrators of a managed-care plan will force courts to engage in the difficult and inappropriate task of distinguishing good managed-care policies from bad ones. *See* Petition for Certiorari at 11. In actuality, it would be the negation of this congressionally enacted cause of action that would constitute an inappropriate act of judicial policymaking.

Enforcement of ERISA's fiduciary obligations in the managed-care context will not require courts to create a new cause of action or undertake inappropriate policymaking. The issue before the Court in such cases is not the wisdom of managed care or even the best way to run a managed-care plan.[11] The matter before the Court is

simply the factual question of whether a particular fiduciary acted in its own interest in carrying out the plan. Resolving such cases requires no unusual policy judgments by the courts. It merely requires the courts to look carefully at the facts of a particular case and determine, as courts routinely do in other cases alleging breach of fiduciary obligation under ERISA, *e.g.*, *Donovan v. Bierwirth*, 680 F.2d 263, 271 (2d Cir.), *cert. denied*, 459 U.S. 1069 (1982); *Reich v. Compton*, 57 F.3d 270, 290-91 (3d Cir. 1995), whether the fiduciary has acted to benefit itself, rather than the beneficiaries as a whole.

Because conflicts of interest are not impermissible per se and because actions undertaken by a "prudent" fiduciary are generally not considered evidence of impermissibly disloyal actions, *see Bierwirth*, 680 F.2d at 271, such determinations are likely to be rare. Any further fear of a flood of litigation should diminish when it is recalled that ERISA does not provide individual plaintiffs with extra-contractual damages. *See, e.g.*, *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134, 144 (1985). An individual beneficiary thus has no incentive to bring a frivolous claim. But in enacting 29 U.S.C. § 1132(a)(2), Congress clearly intended to enable beneficiaries to obtain equitable relief when a plan fiduciary abuses its trust and attempts to enrich itself to the beneficiaries' detriment. Congress never excluded the beneficiaries of health plans from that right, nor did it license breach of trust by health plan administrators. There is no reason or authority for this Court to do so.

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[11] Indeed, the decision whether an employee benefit plan shall be a managed-care plan is primarily the decision of the employer in establishing the plan. There can be no breach of fiduciary duty as long as the fiduciary correctly carries out the plan's instructions. Thus, the suggestion by petitioners that recognition of this cause of action dooms managed care is completely off the mark. *See, e.g.*, Petition for Certiorari at 24-25. To the extent that particular forms of managed care are required by an ERISA plan, they will be untouched by any action under 29 U.S.C. § 1132(a)(2).

CONCLUSION

For the reasons stated herein, *amici* respectfully request that this Court affirm the decision below.

Respectfully submitted,

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APPENDIX A

Health Care For All is a non-profit statewide membership organization based in Boston. HCFA seeks fundamental health care reform for Massachusetts' consumers through policy efforts, advocacy, community organization and public education.

The American Psychiatric Association (APA), with more than 40,000 members, is the Nation's largest organization of physicians specializing in psychiatry. It has participated in numerous cases in this Court, including *Olmstead v. Zimring*, 119 S. Ct. 2176 (1999), *Kansas v. Hendricks*, 521 U.S. 346 (1997), *Jaffee v. Redmond*, 518 U.S. 1 (1996), and *Riggins v. Nevada*, 504 U.S. 127 (1992). The members of the APA have a strong interest in ensuring that decisions about medical care be made in the best interests of patients, without being compromised by the financial pressures often present in managed-care settings or by the dual roles, creating potential conflicts of interest, of the sort alleged in this case.

The Center for Health Care Rights is a California-based non-profit health care consumer advocacy organization dedicated to protecting the rights of health care consumers and working to assure consumer access to quality health care through education, counseling, advocacy and research.

Community Catalyst is a Boston-based national advocacy organization that builds consumer and community participation in the shaping of our health system to ensure quality affordable health care for all.

Connecticut Citizen Action Group is a non-profit consumer advocacy organization based in West Hartford that directs the Health Care For All Coalition, a group of 36 organizations committed to advancing universal access to public health care and reversing the commodification of the health care system.

Consumers for Affordable Health Care Foundation is a non-profit public charity based in Augusta, Maine, whose mission is to assist Maine people in obtaining access to affordable, quality health care. CAHCF accomplishes its mission through advocacy, community organizing, public outreach and education, litigation, and participation in rulemaking proceedings.

Greater Upstate Law Project, Inc. is a non-profit law firm located in Rochester, New York, which represents low-income people throughout upstate New York, and provides legal support services to New York state legal services offices and community groups on civil legal matters that affect their lives and their clients' living, including Medicaid, Medicare and access to health care.

Health Administration Responsibility Project, Inc. is a non-profit California corporation devoted to advocacy, education, and representation of members of Managed Care Organizations.

National Health Law Program is a national non-profit law office that seeks to preserve and improve health care services and health insurance coverage for America's working and unemployed poor through education, advocacy, and policy analysis.

New Hampshire Citizens Alliance is a non-profit membership organization based in Concord that seeks fundamental health care reform through policy efforts, advocacy, community organizing and public education.

Northwest Health Law Advocates is a non-profit organization based in Seattle, Washington, that promotes increased access to health care and basic health care rights and protections for all individuals, through legal and policy advocacy, education and support to community organizations in the Pacific Northwest.

Public Interest Law Center is a non-profit organization established to provide legal advocacy that addresses systemic social and political problems facing residents of New Jersey. One of its focus areas is the growth of managed-care companies and their impact on the delivery of health care from the perspective of patients and providers.

Texas Citizen Fund is a non-profit organization based in Austin, which provides analysis of consumer issues, develops innovative policy and alternatives to existing policies that adversely affect the state's working poor and moderate income families, and builds networks of consumers across the state.

Texas Heart is a non-profit organization dedicated to providing Texans health education, assistance, resources, and training, with a current focus on providing client advocacy on health related matters.